Conclusion

By 1922, statistics from the Catholic Hospital Association (CHA) showed that approximately twenty thousand sisters were caring for the sick in the United States and Canada. From the time of their inception, 675 Catholic hospitals, run mainly by nuns, had cared for four million patients. Catholic sisters were leaders in the CHA and held the voting power. This book set out to more closely examine how this came about. One of the major themes has been the complex ways in which religious women participated in a market economy. By the late nineteenth century, a more urban and industrial era had come of age. In that context, Catholic sisters entered a capitalistic medical marketplace that had developed as immigration brought diverse cultures and religions across the United States. An entrepreneurial ethos emerged among nuns, influencing them to build their congregations and establish, market, finance, and administer complex hospital networks. In the process, they worked with architects, supply companies, contractors, bankers, industrial owners, physicians, and clergy. Sisters’ efficient administration of hospital corporate structures showed that women could be as successful as men in a growing medical marketplace. The leadership and authority of women such as Sister Lidwina Butler, along with scores of other hospital administrators, defied the stereotype of nuns as passive religious women.

Limited endowments meant that Catholic hospitals had to depend on patient fees from the very beginning to carry out their work. Thus, because of economic realities, they were never strictly charity institutions. To maintain financial viability, nuns themselves provided the labor in the early years, although they increasingly transferred nursing care to lay stu-
dent nurses who worked in exchange for their education. Sisters also established bonds with individuals, church leaders, business groups, and local governments. They forged these links because they believed that their nursing and hospitals were integral to the Catholic Church’s ministry. Indeed, institutions had more power to reach people than did individuals. By 1925, all seven hospitals had tremendously expanded their purchasing power. At the same time, questions about hospitals’ reputations, either from the local community or from physicians, could decrease public support, which, considering the competitive medical marketplace, could carry devastating consequences. Indeed, not all sisters’ hospitals were successful. Failures were linked to numerous factors, which included poor planning, unrealistic visions, changing local markets, lack of physicians’ support, or inadequate governmental and public backing.

In the late nineteenth and early twentieth centuries, Catholic hospitals in the Midwest, Texas, and Utah followed much of the standard patterns as those in the East. They expanded in response to social and medical needs, ideas about the germ theory, antiseptic and aseptic surgery, and new technology. In other ways, however, geographic location seems to have accounted for some differences. The Catholic hospitals represented here followed a pattern suggested by Paul Starr. Compared to elite eastern voluntary hospitals that preferred closed medical staffs, Catholic hospitals in the Midwest, Texas, and Utah were open to many qualified physicians. Most of these hospitals also had fewer close ties to large university medical schools. They were more likely to admit patients from diverse backgrounds, including those with tuberculosis, alcoholism, and mental disorders. However, while one might easily conclude that frontier conditions in the Midwest and Trans-Mississippi West allowed sisters greater hospital autonomy, Kathleen Joyce found similar situations in eastern hospitals in which sisters exerted unusual authority.

A second theme of this book has involved the place of gender and religion as frames of reference for understanding sisters’ participation in the hospital marketplace. These were single women who lived in a communal relationship with each other. Through their vow of chastity, they distanced themselves from other women, thereby claiming the respect due them as Roman Catholic sisters. By professing religious vocations, they left behind many of the traditional gender restraints experienced by secular women, and they expanded their activities in the public arena. An important ingredient in their success in dealing with others was their religious image, which included the language they used. When making business proposals or asking for special considerations, they emphasized spiritual aims rather than their own. Even though nuns’ vows called for anonymity,
they were able to use their religious identities to good advantage as they negotiated within and outside hospital walls. Indeed, their religious mantle afforded them special respect and status, and this implicit authority helped them secure higher spiritual and economic returns for their work. Also, those same factors persuaded medical staffs that were accustomed to acting independently to share authority with the sisters.

Ethnic identity also intersected with sisters’ marketplace roles. All three orders originated in France, and the French influence was particularly strong in the Congregation of the Sisters of Charity of the Incarnate Word. French women controlled leadership positions throughout this sixty-year period. Mother St. Pierre Cinquin often relied on spiritual sustenance from the Lyons order. After their arrival in the United States, however, all three congregations assimilated women from Ireland, Germany, Canada, Mexico, and the United States. Religious, economic, and social motives drew entrants to these congregations. With few other occupational choices in their own country, Irish women were especially numerous. Convents served as training grounds not only for Irish nurses but also for congregational leaders and hospital administrators. With a strong sense of economic self-sufficiency, Irish women had major roles to play in the establishment and management of Catholic hospitals across the United States. Many obtained their early training on farms in Ireland. Although some came from poorer families, others did not, and they brought with them the skills they had developed in working in their families’ farming business—bartering, buying land or cattle, and raising money. Sisters also relied on their ethnic bases for financial backing. After the turn of the century, a rising prosperity among Catholic laity, particularly Irish and German, resulted in increased economic support for hospital expansions.

Nuns’ social and economic contributions to their local and regional communities have been another theme of this book. As they purchased goods for hospital construction projects, repair work, and operational supplies, they helped expand local and regional economies. The economies also were aided by the sisters’ successful efforts to bring medical and nursing services to mining and railroad establishments. Sisters started nursing schools and trained many women to work in the region. And Catholic hospitals provided scores of immigrant and American-born women the opportunity for meaningful work. At the same time, nuns’ nursing was a powerful means of spreading religious devotion to patients, and by extension, to the surrounding area. Finally, while sisters increasingly relied on physicians to bring in private patients, their hospitals also provided doctors a vehicle for practice.

Catholic hospitals provided services to a diverse populace with no spe-
cial regard to religious persuasions. However, Catholic immigrants found in sisters’ institutions a common religious and ethnic identity. This was especially true in Indiana and Texas, where Protestantism shaped much of mainstream society. In western states, however, immigrants brought diverse faiths. A pattern of religious pluralism developed and prevented some of the contentious competition that existed in hospitals farther east. Additionally, sister's work with diverse groups of people helped break down the walls of separation that had isolated Catholics from the rest of society.

Nuns' interaction with scientific medicine and the professionalization movement, key indicators of modernity, has been another integrating theme. As hospital owners, sisters had to keep their institutions financially solvent. Yet, they measured their success and usefulness by the number of patients treated, lives and souls saved, and sufferings mitigated. Because they were reluctant to change their methods or purposes as long as those goals were being met, they sometimes needed convincing by local medical authorities of the need to update and modernize. After the hospital standardization movement got underway in the early twentieth century, Catholic hospitals were drawn toward common goals with secular institutions. Through the CHA, nuns had a forum for addressing ways to keep pace with the hospital reform movement. They modernized by admitting secular students to their training programs, hiring secular nurses, and obtaining nursing licensure.

Still, sisters held firmly to their mission of Catholic service. In that regard, they viewed themselves as stewards of the hospital’s resources and bound by their faith to reapply them to aid the sick. This included investments to expand technology, surgery, nursing services, and outpatient facilities that became part of the modern hospital. Improvements in diagnosis and surgery attracted more people who, in years past, would have remained inaccessible to nursing sisters. And as hospitals evolved into curative institutions and mortality rates fell, nuns demonstrated that they could offer substantial opportunities not only for religious salvation and spiritual comfort but also for physical survival and comfort. Well-equipped facilities and competent medical and nursing staffs certainly helped in building public confidence in Catholic hospitals, which in turn influenced admissions and generated income. Also, the sisters’ evolving skills in public relations and marketing endeavors added to the hospitals’ successes. While these successes kindled public trust in hospitals, they also inspired confidence in the nuns’ competence, skill, and spiritual commitment.

Importantly, then, there was no clear dichotomy between charity and marketplace roles for Catholic sister-nurses. Their hospital activities
revealed complex relationships that included interactions of gender, religion, and economic realities. That reality frames the last major theme of this book: how nuns interwove market values with the sacred. One of their most important reasons for raising funds was to provide institutions that integrated medical and religious values. Regardless of geographic location, these hospitals maintained a Catholic identity. Architecture, religious icons, light shining through stained-glass windows, and distinctive ceremonies provided a rich tapestry that reflected the hospital’s Catholic identity. Even the presence of death provided spiritual opportunities for the sisters. Catholic hospitals were places where the dying could make peace with God and organize their spiritual affairs before leaving earthly life. The fact that hospital nursing involved intercession in human death gave great significance to the sisters’ service identities. While providing aid and comfort to the dying, nuns could be mediators to the divine.

Sisters’ spiritual personas were observable as they advertised, raised money, and participated in public religious celebrations. When people entered Catholic hospitals and paid for their care, they bought more than antiseptic conditions, competent doctors, and modern equipment. They also purchased the sisters’ spirituality. Ill persons who suffered, died, or recovered did so in a spiritual environment within the caring presence of sister-nurses. Their attendance, along with the availability of the sacraments, could have as much significance to patients as competent surgeons in safe operating rooms.

Over time, the sisters developed an appreciation of the interrelationship between business and spiritual objectives. They understood that the more financially stable the hospital, and the larger number of people helped, the greater the social and spiritual returns for their work. The end purpose of their entrepreneurship, then, was not to expand profits and market share but rather to advance Catholic spirituality.

Because of the dearth of information heretofore published about nursing sisters, they have been almost invisible in the history of health care and the modern hospital. Perhaps one factor in that omission is simply the fact that, in spite of their religious identities, they still were regarded as women who in their nursing roles were merely doing what has long been assumed to be “women’s work.” Another factor to consider is that hospitals, even those owned by Catholic sisters, are not often thought of as religious institutions. The nuns, of course, did not share that view. As they looked at medical problems and attended to the care of the body, they simultaneously saw spiritual souls. Because their views of suffering, illness, and death were based upon long-standing and deeply held spiritual convictions, it stands to reason that their justification for establishing hospitals
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was much deeper than the simple commitment to acts of charity. Catholic hospitals provided sisters opportunities to nurse the sick and dying, placing nuns in situations that linked the worldly and the divine. Illness and suffering also awakened compassion in nursing sisters and presented them with opportunities for healing and relieving the suffering of others. For the nuns, this certainly included sound medical care but also works of mercy and, at times, divine intervention.

Importantly, medical history has begun to challenge an exclusively somatic conception of illness. Many recent studies have questioned the boundaries between the somatic and psychological. It is logical to expect that such a research movement will now evolve into a deeper study of the spiritual components of health care and medical practice. To assume that illness is exclusively a biological event and that institutions that respond to illness are preeminently secular institutions is shortsighted and narrow. A primary argument of this book has been that, to understand what nuns were doing, the notion of hospitals as inevitably and uniquely medical must be discarded. In reality, Catholic sisters' hospitals were both medical and religious institutions. By recognizing this broader definition of hospitals, conceptions of health and disease must be reevaluated. Indeed, when considering the roles that Catholic sisters played in the hospital marketplace, one must rethink the very meaning of health care. Acknowledging, from the view of history, that the hospital has only recently become a uniquely medical institution invites further studies of why and how people are establishing hospitals.

Finally, this book has addressed the dynamic years of Catholic hospital establishment when sisters' autonomy and influence within the medical marketplace reached their peak. As the twentieth century advanced and pressures to professionalize increased, nuns' religious lives became more regimented and their autonomy more challenged. Additionally, governmental regulations increased, limiting sisters' sovereignty even more. All of these changes affected the identities and business practices of Catholic hospitals. This transition process, its modern outcomes, and its future implications for gender and religious influences upon American health-care institutions call for further study. Among the questions such a study would need to address is whether the forces of economics, governmental control, and professional standardization are inevitably forcing Catholic hospitals to become bland, culturally benign institutions that are virtually indistinguishable from non-sectarian hospitals. If that were, in fact, the future portrait of the American Catholic hospital, then the spiritual components of health care and healing, as emphasized by the nuns in this book, would surely be endangered.